TESTIMONY DELIVERED BY INSURANCE COMMISSIONER JOHN GARAMENDI

TO THE SENATE COMMITTEE ON LABOR AND INDUSTRIAL RELATIONS

WORKERS' COMPENSATION FRAUD INFORMATIONAL HEARING

State Capitol, Room 2040

May 12, 2004

Chairman Alarcón and Committee Members,

When I took office in January, 2003, the burgeoning crisis in the workers' compensation system was just beginning to capture the public's attention. Two dozen insurers had gone bankrupt and dozens of others had fled the market. Because of that, the State Compensation Insurance Fund was growing exponentially - and dangerously.

Out of control medical costs were the primary cost driver behind the system's woes. It lacked adequate cost controls and suffered mightily from rampant abuse and outright fraud. Mr. Chairman, we took aim at that problem along with the leadership of this body, and we developed reforms that I believe will save some $5 billion to $6 billion in system costs annually. That savings, coupled with the impact of the most recent legislative reforms, signals that we have turned the corner on the soaring costs and escalating premiums that have plagued our state's employers for years. I want to thank you again for your work to reform workers' compensation.

During my travels across this state advocating that reform, and in my role as the state's primary insurance regulator, there has been a consistent and sustained call to address one critical element of the problem. It is workers' compensation fraud, and fighting it has been a top priority of my Department since Day 1 of my term.

Although it is difficult, if not impossible, to quantify the amount of workers' compensation fraud and abuse, estimates range between $1 billion and $5 billion annually. The problem begins with the pre-reform workers' compensation statute that was complex, ambiguous, and engendered fraud and abuse. The laws condoned excessive treatments and failed to include effective cost controls. What many people labeled as fraud was actually abuse, in which the excessive and improper use of treatments by medical providers was actually permitted by law. Last year's reforms and the recently enacted reforms will produce significant reductions in abuse as well as fraud because the new law establishes clear medical treatment guidelines, fee schedules, disability guidelines, and other criteria that more clearly define acceptable and unacceptable practices.

As we go about our effort to combat the twin evils of fraud and abuse, our investigations have found an array of schemes, from fraudulent provider billing practices, to medical-legal mills, to applicant fraud, to willfully uninsured businesses, to underreporting of payroll by businesses, and hiding of wages through cash transactions. These criminal activities are perpetuated and encouraged by many factors,

including very expensive insurance, personal and business economic hardship, public indifference to insurance fraud, and inadequate resources to police the problem. Some insurance companies have also been derelict in their responsibility to fight fraud.

Upon taking office I assessed the state of affairs at the Department of Insurance and I took immediate action for change. In no area was that change swifter or more comprehensive than in the fraud-fighting units. I appointed a new chief to head our Fraud Division, Dale Banda. He was directed to focus and prioritize our overall investigative efforts to get the best results for the available resources. I appointed Kathy Scholz to head the Fraud Division's Workers' Compensation Bureau to ensure that our efforts are coordinated with the district attorneys, local law enforcement, the Department of Industrial Relations, the Employment Development Department (EDD), the Fraud Assessment Commission (FAC), and other stakeholders-throughout the state. To ensure success, we determined that we must combat this malady across all lines of insurance by coordinating enforcement efforts with Medi-Cal, auto and health insurance; as well as publicize the results to deter would-be criminals from trying their hand.

The results have been solid and consistent. By nearly every measure the effort against fraud has improved during my first five quarters in office as compared to the same time period during the prior administration:

- The number of cases assigned by the Department for investigation has increased by 51 percent, from 690 to 1046.
- The number of arrests due to Department investigations increased by 53 percent, from 155 to 237
- Department cases submitted to prosecutors are up 117 percent, from 136 to 295
- Department cases filed by prosecutors are up 205 percent, from 86 to 263; while those cases declined for prosecution is down 27 percent, from 48 to 35

Another good example of our success so far is cost effectiveness. In 2003 the amount of insurer premium paid in California was approximately $21 billion. During that same period, the cost of the Department's effort to investigate and prosecute fraud amounted to $34.5 million, or less than .16 percent of the total insurer's premium. With these resources, we were able to prosecute $54,657,482 in chargeable fraud, which represents cases that the district attorneys believe they have enough evidence to support a successful prosecution of the case. The amount of chargeable fraud can vary greatly from year to year depending upon the type and scope of cases tackled and the dollar amount of fraud in each case. These examples show how our concentrated effort has made an impact on workers' compensation fraud in California, and, I am confident that they will improve as we move further into my tenure.

The vast majority of the Audit Report issued on April 29 examined what has been done under previous commissioners, as well as the first year of my administration. The audit touched upon important aspects of the problem of workers' compensation fraud and its impact on employers, and made strong recommendations to enhance our efforts.

Many of the recommendations dovetail with efforts already underway at the Department. Specifically, prior to the audit report we already were: 1) developing a credible approach to measure the amount of fraud in the system; 2) working with state agencies on memorandums of understanding (MOUs) to exchange information and coordinate enforcement efforts; 3) promulgating new emergency regulations that address weaknesses in the insurance carriers anti-fraud efforts; 4) developing procedures to improve overall management of grants to district attorneys; and 5) working closely with the California

District Attorney's Association to target major criminal activities and developing techniques to be more effective in prosecutions. We appreciate the auditors' support of our concepts, as well as additional suggestions that were made.

As the BSA suggested, we will work with the Fraud Assessment Commission to develop the best information available on reported fraud and trends; continue with round-table discussions to plan anti-fraud efforts, and make adjustments to program objectives focused on reducing fraud.
We are amending our business plan for the Fraud Division to incorporate the BSA's suggestions and enhance the already existing initiatives. We will increase accountability required from district attorneys who receive grants from the FAC to combat workers' compensation fraud. And we will sharpen our criteria and rating system that determines which district attorneys should receive funding.

This is just a portion of what we will do in response to the audit and as proactive measures to enhance our fraud fighting program.

I welcome the BSA recommendations because I know that fighting crime of any sort is a team effort. I have enhanced our partnerships and cooperation with local law enforcement entities and our sister state agencies such as the Employment Development Department and the Department of Industrial Resources. Just as I have teamed with those entities, I accept the BSA recommendations in that team spirit.

I also look to the Legislature for its help in this effort. Our Department has proposed or supported strong legislation that would strengthen efforts against fraud, including:

AB 1099 (Negrete-McLeod) which requires the Employment Development Department to share information on workers' compensation fraud with the Department, and additionally added the Workers' Compensation Insurance Rating Bureau to the list of those required to refer cases of workers' compensation fraud. This was signed as part of last year's reforms.

AB 227 (Vargas) increased workers' compensation fraud monetary penalties from a maximum $50,000 fine to a maximum $150,000 fine. This was signed as part of last year's reforms.

AB 1215 (Vargas) would have required EDD to work with SCIF to develop a program that allows insurers offering workers' compensation insurance to have access to quarterly wage and withholding reports filed by insured employers with the Employment Development Department. The insurer shall use the information for the sole purpose of auditing payroll and detecting workers' compensation insurance fraud. This bill was not passed.

SBX4 2 (Speier) enhances the Commissioner's collaboration with the California District Attorney's Association. It is still pending and is pending in this Committee.

SB 899 (Poochigian) extended greater immunity for medical provider fraud referrals to include Administrative Law Judges, audit units and attorneys. This was passed into law.

ABX4 15 (Vargas) makes uninsured employer fraud punishable by jail or prison. Currently, violations of this offense are punished as a misdemeanor. Also allows any person convicted of workers' compensation fraud to be charged the cost of investigation at the discretion of the court, and allows evidence for a search warrant to include evidence that indicates a violation of the uninsured employer provisions. This measure is still pending.

We were unsuccessful in getting the majority of these legislative proposals into the reform bills, but we aren't giving up. I will continue to seek ways to strengthen the laws governing workers' compensation and I hope that the legislature will give my proposals due consideration.

What is important to remember is that insurance companies, including SCIF, are the first line of defense in fighting fraud. They receive the initial complaint from employers and handle every bill from medical- legal mills. Yet many clearly must do more to combat fraud. For example SCIF had around 50% of the market in 2002 yet it reported only 1.82 % of the total referrals that my department received that year. The insurance company role in the fraud fight is laid out in the emergency anti-fraud regulations that I wrote last summer. My staff is now working with the industry to adopt permanent regulations. These regulations will give my office the authority to penalize, when necessary, insurers who fail to report instances of fraud.

Mr. Chairman, there is no doubt that fraud is a serious problem plaguing the workers' compensation system. You and I have both heard the cries of employers who want to crack down on the illegal activity that puts a drain on their ability to operate profitably. I appreciate your interest in ensuring that our state is doing everything possible to address this problem, and I look forward to continuing to work cooperatively with you for the solution.

Thank you

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